
STARFIELD II

HEALTH EQUITY SUMMIT

PRIMARY CARE'S ROLE IN ACHIEVING HEALTH EQUITY

A guidebook to the HEALTH EQUITY CURRICULAR TOOLKIT

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

Martin Luther King Jr.
Chicago, 1966

Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope, and crossing each other from a million different centers of energy and daring, those ripples build a current that can sweep down the mightiest walls of oppression and resistance.

Robert F. Kennedy
South Africa, 1966

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Use of this Guidebook

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INTRODUCTION

This Starfield Summit, held in Portland, Oregon from April 22-25, 2017, brought together a diverse and dynamic group of people with interest in decreasing health disparities and achieving health equity and social accountability.

Thought leaders, primary care clinicians representing numerous organizations, public health experts, educators, researchers, trainees, advocates, policy experts, social service organizations, patients, and community members came together to create a blueprint for the role of health professional schools, primary care, and family medicine in achieving health equity.

This toolkit was inspired by the presentations and discussions at the Summit and is intended to facilitate ongoing conversations to improve equitable outcomes within our communities, locally and nationally. Its goal is to facilitate exploration of some of the most pressing questions of our time as we confront persistent health inequities.

We created a short video called “Orientation to the Health Equity Curricular Toolkit” that may also help acquaint you to this resource: <https://youtu.be/xPo3FXaYiio>.

OVERARCHING GOALS

It is over fifty years since Martin Luther King Jr. said, “Of all the forms of inequality, injustice in health care is the most shocking and inhumane” and yet we continue to live in a land of vast health disparities often determined by the neighborhood and homes we live in or the color of our skin.

Health is a fundamental human right. In 1946, the Constitution of the World Health Organization (WHO) first articulated the right to enjoy the highest attainable standard of physical and mental health. The preamble defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and, moreover, that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”¹

¹ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948..

We hope this toolkit will spur conversation and learning through a collection of modules focusing on critical topics around health disparities and health equity. Ultimately, our goal is to enable users of this toolkit to acquire knowledge, skills and tools to promote and collaborate toward equitable outcomes. We propose a framework of social accountability and will explore this in depth in our introductory module which will be critical foundational work before pursuing all subsequent modules. We also use a consistent socio-ecological framing and equity lens to reinforce the value of these tools in professional practice.

Our goal is *not* to provide answers but to stimulate discussion and hopefully a group-informed collaboration that will lead to ideas, more questions, and maybe some answers. We remind you that Albert Einstein said, “If I had an hour to solve a problem I’d spend 55 minutes thinking about the problem and 5 minutes thinking about solutions.”

A CALL TO ACTION

History

The responsibility of healthcare to partner with communities and invest in a strong civic infrastructure to improve health and health equity has long been understood. The founder of social medicine, Rudolf Virchow, declared in 1849, “For if medicine is really to accomplish its great task, it must intervene in political and social life.” Family medicine was, in fact, founded on the understanding that health and illness occur largely outside of the exam room and its practitioners are called to “accept responsibility for the patient’s total healthcare within the context of environment, including the community and the family or comparable social unit.”²

Present Reality

Unfortunately, due to a wide array of factors, modern healthcare has remained largely focused on curing illness for individual patients, rather than preventing disease with communities. And yet there is growing consensus that that approach is not working. The United States has failed to achieve the Quadruple Aim of improving population health, enhancing patient experiences, reducing healthcare costs, and improving provider satisfaction.³ In addition, poor health outcomes inequitably burden communities of color, and other minority and vulnerable populations.

2 Willard WR. Meeting the challenge of family practice: The report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education. Chicago, IL: Council on Medical Education, American Medical Association;1966.

3 Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med*. 2014 Nov 1;12(6):573-6.

A Call to Action

In light of these persistent disparities, primary care and public health experts have called for the need to address human-made social determinants *of equity*—such as racism, sexism, ageism, ableism, homo- and trans- phobia—that inequitably distribute power, and the social and biological determinants of health along with social determinants of health.^{4,5} For example, median household income (a widely recognized social determinant of health that impacts health outcomes and mortality) is significantly influenced by race/ethnicity as a social determinant of equity, with black households earning \$0.59 for every \$1.00 earned by white households nationally.⁶

There is growing recognition of the need to return to the foundational principles of social medicine and family medicine to more effectively advance health equity. We must move beyond health system-based interventions that merely address individual-by-individual medical and social issues through a direct service model and embrace multi-sectoral community partnerships that can more holistically transform communities and sociopolitical structures. Evidence directs healthcare professionals to move out into the community to address these root causes of health and inequities—and to do so in partnership. Examples include: primary care-public health integration, resident/patient/client engagement, community health improvement plans, multi-sectoral partnerships. Physicians, in particular, should be mindful and strategic in the privileged and thus, powerful, position they hold. They should recognize they need not (and perhaps should not) lead these efforts but advocate through their medically-oriented lens and through the stories they have been entrusted with by their patients and communities to engage policy-makers toward change. Communities—defined geographically or by race/ethnicity—offer significant expertise in, and lived experience with, health-harming factors. Listening to communities builds trust and enhances advocacy efforts. Partnerships valuing everyone’s expertise and assets have the potential to not only improve health and reduce disparities, but to enhance community capacity for sustained social change.⁷

4 Jones CP, Jones CY, Perry GS, Barclay G, Jones CA.. Addressing the social determinants of children's health: a cliff analogy. *J Health Care Poor Underserved*. 2009; 20(4), 1-12.

5 Givens M, Kindig D, Tran Inzeo P, Faust V. Power: The Most Fundamental Cause of Health Inequity? *Health Affairs* website.. <https://www.healthaffairs.org/doi/10.1377/hblog20180129.731387/full/>. Accessed July 26, 2018.

6 Kraus MW, Rucker JM, Richeson JA. Americans misperceive racial economic equality. *Proceedings of the National Academy of Sciences*. 2017;114(39):10324-10331.

7 Geiger HJ, The first community health center in Mississippi: Communities empowering themselves. *Am J Public Health*. 2016; 106(10): 1738-1740

AUDIENCE

While we hope this toolkit will feel accessible to all people engaged in trying to improve primary care and health outcomes for all, our target audience is:

- clinical and public health learners
- primary care faculty who would like an opportunity to further explore this area that often was not intentionally and adequately prioritized in past medical school and residency curricula.

We hope to stretch thinking of facilitators, who are likely educators themselves, as well as their learners and strive toward creative, collaborative solutions.

Each module specifically describes the “appropriate audience” for that module.

- **All learners:** These learners may include medical and other interprofessional students (e.g. nursing and public health students), primary care residents, and faculty and fellows.
- **Advanced learners:** These modules are more appropriate for primary care residents, faculty and fellows, and possibly more advanced medical and other health professional students who have completed several other health equity modules.
- **Faculty and Fellows:** One module is specifically for faculty and fellows and is called “Improving Patient Outcomes by Enhancing Student Understanding of Social Determinants of Health and an Action Learning Approach to Teaching the Social Determinants of Health.”

This toolkit was originally conceived by family physicians who are members of the Health Equity Team for Family Medicine for America’s Health which is why this toolkit is family medicine-centric. Members of this team, however, recognize that collaborating with and learning from people beyond our discipline is essential to achieving health equity and, in fact, have partnered with other interprofessional colleagues in designing the Starfield Health Equity Summit and in creating this toolkit. We hope this toolkit will find a broad audience not only within but also beyond family medicine.

LEARNING MODULES CATEGORIES, FRAMING, AND ORGANIZATION

We will provide a prerequisite two-part introductory module. First, participants will have an opportunity to listen to and discuss Dr. David William’s keynote address illustrating the gravity

of the problem, potential drivers, and inspirational models that offer a pathway to change. Following this will be a deep dive into the conceptual framework of social accountability and the potential for application of an equity lens that is further described below.

After completing the prerequisite module, you will have an opportunity to explore a variety of topics around health equity. We have grouped these critical topics so that they fall within three larger categories: (1) Social Determinants of Health in Primary Care; (2) Vulnerable Populations; and (3) Economics and Policy. Each category offers a valuable lens with which to question and learn. These categories organized our exploration at the Starfield Summit and therefore the modules we offer here.

SOCIAL DETERMINANTS OF HEALTH IN PRIMARY CARE

As we strive for health equity, what social and economic factors must be addressed? Social determinants of health (SDoH) are those “conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes.”⁸ These are now recognized to be the primary drivers of health outcomes across the lifespan, eclipsing both quality of care and access to care. Here, we examine how such experiences shape:

- how people perceive their health and interface with the healthcare system;
- how screening for SDoH could enhance our understanding of our patients’ and communities’ health; and
- how primary care needs to further develop and research evidence-based practices and innovations to link how this “upstreamist” vantage should shape both the practice and education of the primary care workforce.

VULNERABLE POPULATIONS

As we examine health disparities, who lies on the wrong side of the equation? “Vulnerability involves several interrelated dimensions: individual capacities and actions; the availability or lack of intimate and instrumental support; and neighborhood and community resources that may facilitate or hinder personal coping and interpersonal relationships.”⁹ Such a definition brings us closer to an understanding of health *inequities*: “when disparities are strongly and systematically associated with certain social group characteristics such as level of wealth or education, whether one lives in a city or rural area.”¹⁰ We explore disparities through the lens of different populations living in environments that promote vulnerability and add a further layer of complexity as we introduce the topic of “intersectionality.” *For ease of writing we shall*

8 Social Determinants of Health. HealthyPeople.gov website. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> Accessed September 18, 2018.

9 Mechanic D, Tanner J. Vulnerable people, groups, and populations: Societal view. *Health Aff (Millwood)*. 2007;26:1220-1230.

10 Wirth ME, Delamonica E, Sacks E, Balk D, Storeygard A, Minujin A. *Monitoring Health Equity in the MDGs: A Practical Guide*. New York, NY: CIESIN and UNICEF; 2006.

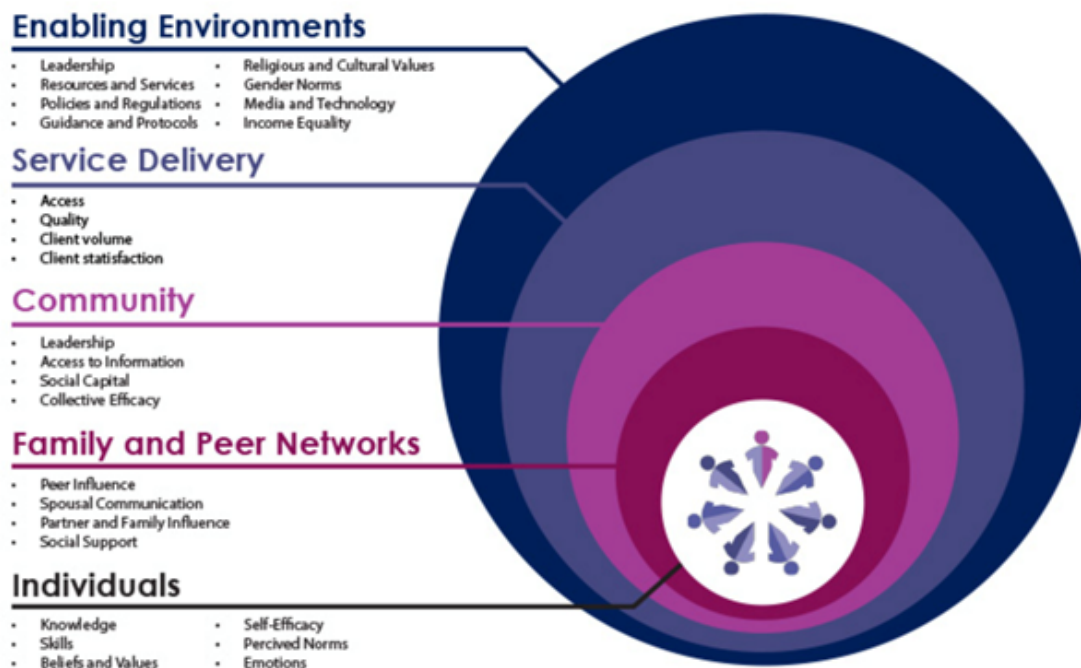
use the term “vulnerable populations” in this toolkit but want to explicitly state that we mean populations living in environments that promote vulnerability.

ECONOMICS AND POLICY

As we strive for lasting change, what systemic factors must change? Combating health inequities requires changes in institutional power and legal structures. Possible solutions can be better understood by looking at global efforts and other creative reforms. For example, Ontario found sizable inequities driven by SDoH in a setting of universal health care. The United Kingdom and New Zealand offer potential models demonstrating payment adjustments based on ecologic SDoH indicators. The Affordable Care Act has opened the way to exploring SDoH as part of its move toward value-based care. Capturing community vital sign data and personal SDoH data has enormous potential to begin the process of leveling the playing field for patients and populations.

SOCIO-ECOLOGICAL FRAMING

We suggest considering a socio-ecological model for navigating each module and offer the following that extends from a micro to a macrosystem level:¹¹



11 Social and Behavioral Change Communication (SBCC) and Gender. The Health Communication Capacity Collaborative. Gender and SBCC Implementation Kits website. <https://sbccimplementationkits.org/gender/sbcc-gender-models-and-frameworks/> Accessed November 19,2017.

We have also included a subheader for each module named “**Related Modules**” that directs you to modules you may wish to explore next.

SOCIAL ACCOUNTABILITY AND AN EQUITY LENS

While there is much to consider to understand the current landscape of health inequities and how to challenge the status quo, we think it would be helpful for users of this toolkit to have an understanding of concepts of social accountability early in the process.

Social accountability—where ordinary citizens and civil society organizations participate in exacting accountability—is a promising frame to assure progress to equitable outcomes. In health care, social accountability prioritizes the health concerns of the people and communities served, with an implicit goal of health equity and, in fact, compels an equity lens.

To facilitate your application of materials in each module to your professional practice, we will pose reflective questions based upon the Equity and Empowerment Lens’ 5Ps—Purpose, People, Place, Process, Power.¹² This will be further reviewed in the prerequisite module. Briefly, the Equity and Empowerment Lens “is a transformative quality improvement tool used to improve planning, decision-making, and resource allocation leading to more...equitable policies and programs. At its core, it is a set of principles, reflective questions, and processes that focuses at the individual, institutional, and systemic levels by:

- deconstructing what is not working around [health] equity;
- reconstructing and supporting what is working;
- shifting the way we make decisions and think about this work; and
- healing and transforming our structures, our environments, and ourselves.”¹³

It was designed with a racial justice focus to achieve racial equity; we are adapting it to apply broadly to health equity, which is inclusive of racial justice.

12 What is the Equity and Empowerment Lens? Multnomah County website. <https://multco.us/diversity-equity/equity-and-empowerment-lens> Accessed September 18, 2018.

13 What is the Equity and Empowerment Lens? Available at: <https://multco.us/diversity-equity/equity-and-empowerment-lens>

MODULE ORGANIZATION

Each module contains the following elements:

- Learning objectives
- Brief background/context
- “Ignite” video (each about 6-12 minutes*) led by an expert in the field and the accompanying slides
- A series of proposed questions for the facilitator for group discussion
- An invitation to propose an actionable response to the discussion with an opportunity to apply an equity lens
- Links to material in an annotated bibliography for more in depth reading and more advanced discussion
- A list of high level health equity resources are included at the end of the Guidebook to consider when exploring questions in the modules
- A list of words and concepts used in the module that are defined at the end of this guidebook at the end of this toolkit to encourage common language and base understanding for facilitators and learners

*The prerequisite introductory module is a larger two-part module with about 90 minutes of video material.

ESSENTIAL THOUGHTS ABOUT USING THE TOOLKIT

A fifteen-minute video called “Facilitating Conversations about Inequity, Oppression, and Privilege” was created to support facilitators: <https://youtu.be/aE9s-sGt0js>.

FOR THE FACILITATOR

We recognize that few of us will be true experts in this field but believe your knowledge of your learners and your desire to better teach issues around population and community health is a critical starting place.

The toolkit is meant to provide you with easy-to access resources and a potential guide for teaching. Please feel free to adapt and further develop your own learning objectives and aspirations—the creative commons license and academic freedom encourage it!

Being able to teach about complex topics such as racism and sexism is an important component to teaching about ways to move the conversation toward health equity. Although one of our modules begins to address this, we recognize that this is a particularly complicated area that is worthy of a longitudinal course to assure we pursue a journey toward cultural humility and self-reflection. While beyond the scope of the toolkit, we will provide other resources in our annotated bibliography.

Below are facilitator instructions from the “Toolkit for teaching about racism in the context of persistent health and healthcare disparities” that you may find useful before teaching areas that may be personally triggering.¹⁴

BEFORE THE LEARNING SESSION:

Take some time to self-reflect.

- What are comments, situations, and feelings that trigger you? How will you handle it if they come up during the session that you are leading?
- What is your style of communication and interaction? Are you an extrovert/introvert, silent/verbal processor, confrontational/avoidant, or cerebral/emotive? Are you strict or flexible with agenda timing? It is important to know your style so that you can facilitate intentionally.
- What are you hoping to accomplish during the session? This will help you plan effective activities to accomplish the desired goal. A session with the goal of winning buy-in for curriculum development will look very different than attempting to create a more

¹⁴ Adapted from Edgoose J et al. Toolkit for teaching about racism in the context of persistent health and healthcare disparities. Draft manuscript pending submission.

engaged discussion about the impacts of racism with students. This will also help prevent you from projecting your own goals onto the discussion ineffectively.

- Consider the impact of your own identity. What might facilitators from advantaged groups (e.g. male, white) need to be sensitive of? What might facilitators from disadvantaged groups (e.g. women, People of Color [POC]) need to be sensitive of?)

DURING THE LEARNING SESSION

Guidelines for Group Discussion Setting ground rules explicitly and intentionally at the beginning of a group experience can be a helpful and affirming exercise. It may be valuable to share these guidelines with your group by printing this out for each participant or hanging it on a wall. Ask if everyone can abide by these rules and if they would offer any additional ones for your particular group.

- What you share within the context of the conversation is confidential, honored, and respected.
- Use “I” statements— avoid speaking for another or for an entire group.
- Avoid critiquing others’ experiences; focus on your own experiences.
- Be honest, willing to share, and vulnerable.
- Use the “Step Up, Step Back” approach. If you tend to be quieter in groups, challenge yourself to share. If you tend to share, make sure there is space for others to share.
- Listen with curiosity and the willingness to learn and change; resist the desire to interrupt.
- Suspend judgment. Be open to the wisdom in each person’s story.
- Be brave and lean into discomfort.
- Address differences intentionally.
- Accept non-closure.
- Reflect upon the emotions that you are feeling and what might be causing them.

General Do's and Don'ts of Facilitating

- **Do** listen attentively
- **Do** be aware of your emotional resilience
- **Do** practice empathy
- **Do** guide conversation back to focus
- **Do** refer to stories that people have shared (in a large group setting)
- **Do** be prepared that everyone may not agree with your point of view
- **Do** explore emotions in addition to content
- **Don't** take anything personally
- **Don't** teach/preach
- **Don't** cut people off
- **Don't** make anyone a spokesperson
- **Don't** monopolize the conversation
- **Don't** allow intolerant speech
- **Don't** rescue or reassure white people
- **Don't** turn to disadvantaged groups such as people of color as experts
- **Don't** ignore conflict/tensi

Things to Remember If Things Get Tense

- Take a deep breath and check your pulse—remind yourself: tension is good, this means people are being honest and it's likely an opportunity to explore something significant
- Don't panic
- Call the tension out and name it —trying to diffuse it without directly addressing frequently makes things worse, causes a loss of trust/engagement, and can be dismissive
- Take a break from the content of the conversation to explore the emotions that are being felt
- Return to the group discussion norms to guide the conversation back to engaging rather than attacking
- Help people clarify what they are saying and thinking with genuine curiosity
- Slow down the conversation and take things step-by-step

The most important thing to remember is that your behavior is just as instructive as any content you provide. You are modeling the patience, compassion, curiosity, and courage that you would like your participants to practice.

- Use your own mistakes as a transparent learning session. Apologize and recognize why what you said or did was painful or ignorant. Openly discuss the mistake you made and what biases reveal in your own self. Model that it's ok to make mistakes; what's most important is what we do afterwards.
- Be present. Don't just plan what you're going to say next. You are allowed to think after someone speaks, and it models thoughtful behavior for others to emulate.

Guidance for Groups with Interprofessional Learners

Many of the guidelines we offer for facilitators above are aptly applied to interprofessional groups. However, since having groups made up of different disciplines can add additional complexity to what might already be tender topics for many participants, we offer a few additional thoughts and resources. Be aware of the following potential facilitation challenges when working with interprofessional groups, and consider these suggestions to address them:

Facilitation Challenges¹⁵	Potential Remedies
Unique professional learning requirements that may influence conversations	Be inquisitive—ask students to explain their disciplinary perspective on a topic if you have a hunch this is at play.
Generalizations/stereotypes that students may have about different professionals	Call these out as you would any stereotypes; invite students to explain why the generalization is inaccurate.
Applicability of case examples to all students	Modify case examples to be more inclusive of diverse professions. Ideally do this before the class session, but if necessary do so on the fly.
Use of jargon by students	Ask students to explain terms they use. Modeling this behavior encourages future/ young professionals to do this in other contexts.

Additional resources for teaching interprofessional groups are included at the end of the Guidebook.

¹⁵ IPE Facilitation Training Toolkit. Section 2. Common Facilitation Challenges. Section 4. Materials: Facilitation Pocket Guide. Center for Health Sciences Interprofessional Education University of Washington website. <https://collaborate.uw.edu/ipe-teaching-resources/ip-curriculum-educators/ipe-facilitation-training-toolkit/> Accessed September 18, 2018.

A Guide to Creating Supplemental Questions

While we welcome you to use our included questions, we encourage you to supplement these with your own. Here are some examples of the types of questions facilitators might pose:¹⁶

Interest-getting questions. Example: "How do you think colleagues would react if you got involved in advocacy efforts regarding increasing the primary care workforce?"

Diagnosing and checking questions. Example: "How would the principles of Community Based Participatory Research (CBPR) be helpful in this situation?"

Recall of specific facts or information questions. Example: "What do you interpret the authors of Health Care Advocacy as saying about the role of lobbying in legislative advocacy?"

Structure and redirect learning questions. Example: "Now that we have discussed the advantages of, and limitations to utilizing patient anecdotes in legislative advocacy, who can do the same for the use of data/evidence?"

Allow expression of affect questions. Example: "How did you feel about the controversy around physician advocacy?"

Encourage higher level thought processes questions. Example: "Considering what you have read, and what was discussed in the posts this past week, can you summarize all the advantages to engaging patients in quality improvement efforts in organizations?"

¹⁶Davis S. Advocating for populations: Partnering to improve community health. Discussion Forum Facilitators Guide. 2014. Center for Patient Partnerships. Madison, WI. On file with the author.

FOR THE LEARNER

Your active participation is critical. Sharing of your experiences will be as important as conveying your understanding. As this topic is often literally a discussion about the “haves” and “have-nots” it will often be a complex discussion of power and privilege. If you tend to be a quiet participant, we encourage you to exercise your voice. If you tend to be a vocal participant, pause and think how your contributions can help enable others to contribute or perhaps simply listen to the thoughts of others.

Exploring the questions posed in many of the modules will invariably be most fruitful when considered collectively and not individually. If you find that you do not understand or agree with another participant, get curious and ask them to explain why. Be vulnerable and humble—share that you would welcome additional information to guide your learning.

Do you find that you talk more when you are uncomfortable? Consider these tips: Resist the urge and lean into listening. Write down your thoughts instead of saying them out loud.

DEFINITIONS

Asset-Based Community Development: Asset-based community development methodology is used to promote the sustainable development of communities based on their strengths and potentials. The assessment tool is used to assess the resources, skills and experience available within a given community. The assessment information is used to organize the community, and builds on the skills of the local residents, the power of local associations, and the supportive functions of local institutions.

Asylum Seeker: See refugee.

Community: A group of people who have common characteristics; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other common bonds. Individuals with a shared affinity, and perhaps geography, who organize around an issue, with collective discussion, decision making, and action.

- Turnock BJ. *Public Health: What it Is and How It Works.*, MA:Jones and Bartlett Learning, LLC; 2016.
- Labonte R. Health promotion: From concepts to strategies. *Health Manage Forum.* 1988;1(3):24-30.

Community and Education Based Framework: Community and education based frameworks embrace new ways of learning and prepare faculty through community and collaborative partnerships. Fitzgerald et al (2012) describe this framework as: Embracing engagement as an aspect of learning and discovery that enhances society and higher education. Community engagement is an understanding that not all knowledge and expertise resides in the academy and that both expertise and great learning opportunities in teaching and scholarship also reside in nonacademic settings.

- Fitzgerald H, Bruns K, Sonka S, Furco A, Swanson L. The centrality of engagement in higher education. *J High Educ Outreach Engagem.* 2012;16(3):7-27.

Community Assessment: The Public Health Accreditation board defines community health assessment as a systematic examination of the health status indicators for a given population used to identify key problems and assets in a community.

Community Driven: Community driven, as defined by the World Bank Group, gives the control of decisions and resources to community groups. The community is treated as assets and partners in the development process, building on their institutions and resources.

Community Engagement: The process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. In general, goals of community engagement are to build trust, enlist new resources and allies, create better communication, and improve overall health outcomes as successful projects evolve into lasting collaborations.

- Principles of Community Engagement. 2nd ed. Centers for Disease Control and Prevention (CDC).
https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf. Accessed on September 15, 2018.

Community Health: A perspective on public health that assumes community to be an essential determinant of health and the indispensable ingredient for effective public health practice. It takes into account the tangible and intangible characteristics of the community – its formal and informal networks and support systems, its norms and cultural nuances, and its institutions, politics, and belief systems.

- Kindig DA. Understanding population health terminology. *Milbank Q* 2007;85(1):139-161.

Community Health Center (CHC):- Also known as Federally Qualified Health Center (FQHC); a primary care clinic with a mission to serve low-income and underserved communities.

- Wallace SP, Young M, Rodríguez MA, et al. Community health centers play a critical role in caring for the remaining uninsured in the affordable care act era.
https://blumcenter.ucla.edu/files/view/policydocs/FQHC_PB-oct2016.pdf. *Policy Brief UCLA Cent Health Policy Res*. Published October 2016.(PB2016-7):1-8. Accessed June 9, 2018.

Community Vital Signs: Incorporating geocoded social determinants into electronic records to promote patient and population health. *J Am Med Inform Assoc*. 2016 Mar;23(2):407-412.

Community Health Improvement Plan (HIP): A long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and

coordinate and target resources. A HIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done in a timely way. This definition of community health improvement plan also refers to a tribal, state or territorial community health improvement plan.

- Community Health Assessments & Health Improvement Plans. Center for Disease Control and Prevention. <https://www.cdc.gov/stltpublichealth/cha/plan.html>. Accessed September 27, 2018.

Community Health Needs Assessment: A process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community. An ideal assessment includes information on risk factors, quality of life, mortality, morbidity, community assets, forces of change, social determinants of health and health inequity, and information on how well the public health system provides essential services. Community health assessment data are intended to inform community decision making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans.

- Definitions of Community Health Assessments (CHA) and Community Health Improvement Plans (CHIPs). National Association of City and County Health Officials (NACCHO). <http://archived.naccho.org/topics/infrastructure/community-health-assessment-and-improvement-planning/upload/Definitions.pdf>. Accessed on June 9, 2018.

Community Health Needs Assessment (CHNA) –Internal Revenue Service (IRS): A CHNA is required under the IRSCode by the Patient Protection and Affordable Care Act (ACA). The IRS requires hospital organizations to document compliance with CHNA requirements for each of their facilities in a written report that includes:

- A description of the community served
- A description of the process and methods used to conduct the assessment
- A description of methods used to include input from people representing the broad interests of the community served
- A prioritized description of all community health needs identified in the CHNA, as well as a description of the process and criteria used in prioritizing such needs
- A description of existing health care facilities and other resources in the community available to meet the needs identified in the CHNA. <https://www.irs.gov/pub/irs-drop/n-11-52.pdf>

Community Health Worker (CHW): A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

- Community Health Workers. American Public Health Association. <https://www.apha.org/apha-communities/member-sections/community-health-workers>. Accessed September 27, 2018.

Cultural Competence: The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

- Davis K. *Exploring the Intersection Between Cultural Competency and Managed Behavioral Health Care Policy: Implications for State and County Mental Health Agencies*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning; 1997.

Deprivation Index: Uses data representing aspects of material and social deprivation from censuses or from administrative data sets. Such indices are designed to measure socioeconomic variation across communities, assess community needs, inform research, adjust clinical funding, allocate community resources, and determine policy impact.

- Phillips RL, Liaw W, Crampton P, et al. How Other Countries Use Deprivation Indices— And Why the United States Desperately Needs One. *Health Aff.* 2016;35(11):1991-1998.

Developmental Disabilities: A group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during the developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime. (CDC)

Disability: A physical or mental impairment that substantially limits one or more major life activity (*refers to lifelong or acquired conditions*).

- Americans with Disabilities Act of 1990, As amended. <https://www.ada.gov/pubs/adastatute08.htm#12102>. Accessed September 15, 2018.

Downstream Determinants of Public Health (Downstream): Maybe seen as the outcomes of upstream factors and variables. In some respects, downstream determinants are more easily mitigated or prevented by the individual, such as a change in eating habits or reducing risk of injury on the job.

Electronic health record (EHR): A systematized collection of patient health information that is stored electronically.

Equity Lens: A transformative quality improvement tool used to improve planning, decision-making, and resource allocation leading to more equitable policies and programs.

Geocoded Data: The process of joining a fact or data point together with a description of its location—such as a pair of coordinates, an address, or a name of a place—such that it can be localized to a single point or geographically defined area (e.g. census block, zip code, county, state) on the earth's surface, allowing it to be used for mapping or spatial analysis.

Global Health: Health problems, issues, and concerns that transcend national boundaries, may be influenced by encounters or experiences in other countries, and are best addressed by cooperative efforts and solutions.

- Starfield B. Global health, equity, and primary care. *J Am Board Fam Med.* 2007; 20(6):511-513.

Health: A state of complete physical, mental, and social well-being and not just the absence of sickness or frailty (CDC).

- Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, N.Y., 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Health Disparities: A preventable excess morbidity and mortality that impacts a group of people. It is “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

- National Partnership for Action to End Health Disparities. U.S. Department of Health and Human Services website.
<http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34>. Accessed on June 9, 2018.

Health Care Disparities: “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.”

- Smedley, BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Policy, Institute of Medicine. Washington, DC: National Academy Press; 2003.

Health Disparity Populations: A significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population (National Institute on Minority Health and Health Disparities)

Health Equity: The absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage —that is wealth, power, or prestige. Equity is an ethical principle; it also is consonant with and closely related to human rights principles.

- Braveman P, Gruskin S. Defining equity in health. *Journal of Epidemiol Community Health*. 2003;57:254-258.

Health/Patient Experiences: “encompasses the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities. As an integral component of healthcare quality, patient experience includes several aspects of healthcare delivery that patients value highly when they seek and receive care, such as getting timely appointments, easy access to information, and good communication with healthcare providers. Understanding patient experience is a key step in moving toward patient-centered care. By looking at various aspects of patient experience, one can assess the extent to which patients are receiving care that is respectful of and responsive to individual patient preferences, needs and values. Evaluating patient experience along with other components such as effectiveness and safety of care is essential to providing a complete picture of healthcare quality.”

- What Is Patient Experience? Agency for Healthcare Research and Quality website. . <http://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html>. Accessed June 9, 2018.

“patient[s] tell[ing] the story of what has happened to them in their own way, focusing on the issues that are important to them.”

- Ziebland S, Coulter A, Calabrese J, Locock L, eds. *Understanding and Using Health Experiences. Improving Patient Care*. Oxford, UK: Oxford University Press;2013.

Health Experiences Research: Research that aims to find out what is important to participants, including what meanings they attach to health and illness and how they behave as a result. It sheds light on how people understand, explain and adapt to their changing health.

- Definition adapted from Ziebland S, Coulter A, Calabrese J, Locock L, eds. *Understanding and Using Health Experiences. Improving Patient Care*. Ziebland et al (Eds). Oxford, UK: Oxford University Press;2013.

Health Inequality: Differences, variations, and disparities in the health achievements of individuals and groups of people.

- Kawachi I. A glossary for health inequalities. *J Epidemiol and Community Health*. 2002;56(9):647.

Health Inequity: A difference or disparity in health outcomes that is systematic, avoidable, and unjust.

- Braveman PA. Monitoring equity in health and healthcare: A conceptual framework. *J Health Popul Nutr*. 2003;21(3):181.
- Whitehead, M. The concepts and principles of equity and health. *Health Promot Int*. 1991. 6(3):217.

Health Professional Shortage Areas (HPSAs): Designations that indicate health care provider shortages in primary care, dental health, or mental health. Shortages may be geographic-, population- (e.g., low income, migrant farmworkers), or facility-based (e.g., correctional facility, mental health facility, Indian health facility).

- Health Professional Shortage Areas (HPSAs). Health Resources and Services Administration website. <https://bhw.hrsa.gov/shortage-designation/hpsas>. Accessed June 9, 2018.

Hispanic: The U.S. Office of Management and Budget (OMB) requires federal agencies to use a minimum of two ethnicities in collecting and reporting data: Hispanic or Latino and Not Hispanic or Latino. OMB defines "Hispanic or Latino" as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. (see Latino/Latina/Latinx)

- Hispanic Origin. United States Census Bureau website. <https://www.census.gov/topics/population/hispanic-origin/about.html>. Accessed May 12, 2018.

Immigrant: Any foreign national who enters a country for purposes of permanent resettlement.

- Martinez O, Wu E, Sandfort T, et. al. Evaluating the impact of immigration policies on health status among undocumented immigrants: Asystematic review. *J Immigr Minor Health*. 2015 Jun;17(3):947-70.

Implicit Bias: see unconscious bias.

Individual Level Social Determinants: Social determinants that present as barriers to student success which can include but are not limited to inadequate financial support, lack of emotional and moral support, a sense of isolation and loneliness, discrimination, lack of advising and academic success, lack of mentors and role models, little sense of professional socialization, limited computer access and technology competency and deficiency of cultural competence.

Intellectual Disabilities: Disabilities characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills. These disabilities originate before the age of 18.

- American Association on Intellectual and Developmental Disabilities (AAIDD). <http://aidd.org/intellectual-disability/definition>. Accessed September 15, 2018.

Intersectionality: A framework that considers different sources of social inequality (e.g., race, gender, social class) collectively, rather than in isolation, as determinants that shape the degree of advantage or disadvantage experienced by a given person, community, or population.

Latino/Latina/Latinx: While “Latino” and “Hispanic” are two terms sometimes used interchangeably, “Hispanic” is a narrower term that only refers to persons of Spanish-speaking origin or ancestry, while “Latino” is more frequently used to refer generally to anyone of Latin American origin or ancestry, including Brazilians. The United States Census Bureau, however, uses “Hispanic” and “Latino” interchangeably. “Latino” refers technically to males and “Latina” to females so “Latinx” (first used in 2004) has been growing in popularity as the gender neutral term often used in lieu of *Latino* or *Latina* (referencing [Latin American](#) cultural or racial identity)

- Hispanic Origin. United States Census Bureau website. <https://www.census.gov/topics/population/hispanic-origin/about.html>. Accessed May 12, 2018.

- Hispanic-Latino naming dispute. Wikipedia website. https://en.wikipedia.org/wiki/Hispanic%E2%80%93Latino_naming_dispute. Accessed May 12, 2018.
- Latinx. Wikipedia website. <https://en.wikipedia.org/wiki/Latinx>. Accessed May 12, 2018.

Learning Healthcare System: A system in which, “science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience.”

- Institute of Medicine (IOM).2007. The Learning Healthcare System: Workshop Summary. Washington, DC: The National Academies Press.

Medically Underserved Populations: Specific sub-groups of people living in a defined geographic area with a shortage of primary care health services. These groups may face economic, cultural, or linguistic barriers to health care.

- Medically Underserved Areas and Populations (MUA/Ps). Health Resources and Services Administration website. <https://bhw.hrsa.gov/shortage-designation/muap>. Accessed September 26, 2018.

Microaggressions: Brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership.

- Sue DW, Capodilupo C, Torino GC, et al. Racial microaggressions in everyday life: Implications for clinical practice. *Am Psychol*. 2007;62(4):271-286.

Minority: “Any group of people who, because of their physical or cultural characteristics, are singled out from the others in the society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination.”

- Wirth L. The problems of minority groups. In *The Science of Man in The World Crisis*. Ralph Linton, ed. New York: Columbia University Press.

Oppression: The systemic and pervasive nature of social inequality woven throughout social institutions as well as embedded within individual consciousness. Oppression fuses institutional and systemic discrimination, personal bias, bigotry and social prejudice in a complex web of relationships and structures that saturate most aspects of life in our society.

- Adams M, Bell LA, Griffin P, eds. *Teaching for Diversity and Social Justice: A Sourcebook*. New York, NY: Routledge;2016.

Patient and Family Engagement: Patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system—

direct care, organizational design and governance, and policy making to improve health and health care

- Carman Kristin L, Dardess P, Maurer M, et al. Patient and family engagement: A framework for understanding the elements and developing interventions and policies. *Health Affairs*. 2013;32(2) 223-31.
<https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.1133>. Accessed September 26, 2018.
- **PCORI defines Engagement in Research as** “the meaningful involvement of patients, caregivers, clinicians, and other healthcare stakeholders throughout the research process—from topic selection through design and conduct of research to dissemination of results.” PCORI “believe[s] that such engagement can influence research to be more patient centered, useful, and trustworthy and ultimately lead to greater use and uptake of research results by the patient and broader healthcare community.”
 - What We Mean by Engagement. Patient-Centered Outcomes Research website. <https://www.pcori.org/engagement/what-we-mean-engagement>. Accessed June 9, 2018.

Patient/Health Experiences: see Health/Patient Experiences.

Patient-Centered: Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

- Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.

Patient-Centered Outcomes/Patient Reported Outcomes (PROs): PROs are defined by the Food & Drug Administration (FDA) and National Quality Forum (NQF) as “... a report that comes directly from the patient (i.e., study subject) about the status of a patient’s health condition without amendment or interpretation of the patient’s response by a clinician or anyone else.” ‘Outcome’ in reflects a variety of information reported directly by the patient, including health-related quality of life, functional status, symptoms, and treatment adherence. PROs are distinct from other patient outcomes such as physiological measures (e.g., hemoglobin A1c), clinician-reported measures (e.g., global impressions), and caregiver-reported measures. Patient-centered outcomes research (PCOR) stresses the importance of research “informed by the perspectives, interests and values of patients” throughout the research process, thereby incorporating PROs.

- Snyder CF, Jensen RE, Segal JB, Wu AW. Patient-reported outcomes (PROs): Putting the patient perspective in patient-centered outcomes research. *Med Care*. 2013;51(8 Suppl 3):S73-S79. (Citing FDA, NQF, and PCORI)

Patient Navigator: a person who provides individualized assistance to help a patient overcome health care system barriers and facilitate timely access to quality medical and psychosocial care.

- Natale-Pereira A, Enard K, Nevarez L, Jones L. The role of patient navigators in eliminating health disparities. *Cancer*. 2011;117 (15 Suppl):3543-3552.

Place-based Initiative: Establishing inclusive participatory community-based strategy as the basis for action, planning and implementation.

- Dankwa-Mullan I, Perez-Stable E. Addressing health disparities is a place-based issue. *Am J of Public Health*. 2016;106(4):637-639.

Population Health:

1. A conceptual framework for thinking about why some populations are healthier than others, as well as the policy development, research agenda, and resource allocation that flow from it.
2. The health outcomes of a group of individuals, including the distribution of such outcomes within the group.
3. The health of a population as measured by health status indicators and as influenced by social, economic, and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services.
 - Kindig DA. Understanding population health terminology. *Milbank Q* 2007;85(1):139-161.

Poverty:

- **Absolute Poverty:** A condition characterized by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services.
- **Relative Poverty:** One's status with regard to the economic condition of other members of the society: people are poor if they fall below prevailing standards of living in a given societal context.
- **Income Poverty:** a form of relative poverty; when an individual's or family's income fails to meet a federally established threshold that differs across countries.

- **Extreme Poverty:** Individual/family income less than the international standard of \$1/day.
 - o Poverty. Paris: United Nations Educational, Scientific and Cultural Organization website. <http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/poverty/>. Accessed June 9, 2018.

Power: In social science and politics, power is the ability to influence or outright control the behavior of people. The term “authority” is often used for power perceived as legitimate by the social structure. Power can be seen as evil or unjust, but the exercise of power is accepted as endemic to humans as social beings. A discussion of attending to power as a determinant is emerging in health equity scholarship. See also “Resources” and “Structural Inequality.”

- Luthans F, Luthans BC, Luthans KW. Organizational Behavior: An Evidence Based Approach, 13th Ed. 2015.
- Givens M, Kindig D, Tran Inzeo, P, Faust V. Power: The most fundamental cause of health inequity? *Health Affairs* Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20180129.731387/full/>. Accessed May 15, 2018.

Primary Care: Primary care is first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system.

- Starfield B. Is primary care essential? *Lancet*. 1994;344(8930):1129-1133.

Privilege: Privilege operates on personal, interpersonal, cultural, and institutional levels and gives advantages, favors, and benefits to members of dominant groups at the expense of members of target groups. In the United States, privilege is granted to people who have membership in one or more of these social identity groups:

- | | |
|-----------------------|----------------------------------|
| ● White people; | ● Christians; |
| ● Able-bodied people; | ● Middle or owning class people; |
| ● Heterosexuals; | ● Middle-aged people; |
| ● Males; | ● English-speaking people. |

Privilege is characteristically invisible to people who have it. People in dominant groups often believe that they have earned the privileges that they enjoy or that everyone could have access to these privileges if only they worked to earn them. In fact, privileges are unearned and they are granted to people in the dominant groups whether they want those privileges or not and regardless of their stated intent.

Unlike targets of oppression, people in dominant groups are frequently unaware that they are members of the dominant group due to the privilege of being able to see themselves as persons rather than stereotypes.

- Morrison M. Seminar presented: *Doing Our Own Work: A Seminar for Anti-Racist White Women*; 2003;Leaven Center; Lyons, MI.

Public Health:

1. Activities that a society undertakes to assure the conditions in which people can be healthy. These include organized community efforts to prevent, identify, and counter threats to the health of the public.
 - Kindig DA. Understanding population health terminology. *Milbank Q* 2007;85(1):139-161.
2. What we as a society do collectively to assure the conditions in which people can be healthy.
 - Institute of Medicine. *The Future of Public Health*. Washington, DC: National Academy Press; 1998.
3. The science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals.
 - Winslow CEA. The untilled fields of public health. *Science*.1920;2:183–91.

Quality Improvement: “the combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.” Also referred to as “Continuous Improvement.”

- Batalden PB, Davidoff F. What is “quality improvement” and how can it transform healthcare? *Quality & Safety in Health Care*. 2007;16(1):2-3.
- See also Learning Healthcare System

Quality Improvement: The attainment or process of attaining a new level of performance or quality.

- Quality improvement MeSH descriptor data 2018. U.S. National Library of Medicine webpage..<https://meshb.nlm.nih.gov/record/ui?ui=D058996>. Accessed August 29, 2018.

Race: A social construct created to divide people in order to prevent the majority of people from rising up against those with wealth and power. It has been woven into the very fabric of our society. While it is not a biological reality, it has a very real and profound social reality and impact on the lives of people of color.

- Adelman L. Race and gene studies: What differences make a difference? *Race—The Power of an Illusion*. PBS website. http://www.pbs.org/race/000_About/002_04-background-01-02.htm. Accessed September 15, 2018.

Racism: A system of structuring opportunity and assigning value based on the social interpretation of how one looks (“race”). It unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.

- Jones CP. Confronting institutionalized racism. *Phylon* 2003;50(1-2):7-22.

Refugee/Asylum Seeker: any person who enters a country to avoid persecution.

- Martinez O, Wu E, Sandfort T. et al. Evaluating the impact of immigration policies on health status among undocumented immigrants: A systematic review. *J Immigr Minor Health*. 2015;17(3):947-70.

Relational: The way in which people and communities are connected. For example, power is a relational concept that can only be understood in terms of interactions between individuals and groups.

- *Oxford English Dictionaries*. Oxford University Press.

“Representative” Input: “representing the broadest possible range of health experiences.”

- Our Methods. healthexperienceusa.org website. <http://healthexperienceusa.org/our-methods/> Accessed on June 9, 2018.

Resources: “We define resources broadly to include money, knowledge, power, prestige, and the kinds of interpersonal resources embodied in the concepts of social support and social network.”

- Link BG, Phelan J. Social conditions as fundamental causes of disease. *J Health Soc Behav* 1995 Jan 1:80-94.

Risk Adjustment: A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs. For health equity, it is “Social Risk Factors” that are adjusted for.

- HealthCare.gov website. <https://www.healthcare.gov/glossary/risk-adjustment/>. Accessed June 9, 2018.

- Joynt KE, De Lew N, Sheingold SH, Conway PH, Goodrich K, Epstein AM. Should medicare value-based purchasing take social risk into account? *New Engl J Med*. 2017;376(6):510-3.

Rural:

1. Anything that is not urban (i.e. population <2,500) (US Census Bureau)
 2. Non-metropolitan counties (core area population < 50,000)(Office of Management and Budget)
 3. Combine definitions 1 and 2 with rural urban commuting area (RUCA)codes (a measure of commuting time and distance, developed by the University of Washington) (HRSA Office of Rural Health Policy)
- Defining Rural Population. Health Resources and Service Administration website. <https://www.hrsa.gov/rural-health/about-us/definition/index.html>. Accessed June 9, 2018.

Service Learning: A structured learning experience that combines community service with preparation and reflection. Students engaged in service learning provide community service in response to community-identified concerns and learn about the context in which service is provided, the connection between their service and their academic coursework, and their role as citizens.

Sexism: Prejudice or discrimination based on a person's sex or gender. "Sexism is the foundation on which all tyranny is built. Every social form of hierarchy and abuse is modeled on male-over-female domination." -- Andrea Dworkin

Social Accountability: "an approach towards building accountability that relies on civic engagement, i.e., in which it is ordinary citizens and/or civil society organizations who participate directly or indirectly in exacting accountability."

- Ackerman JM. Social accountability in the public sector: A conceptual discussion. Social Development Papers. World Bank. http://siteresources.worldbank.org/WBI/Resources/Social_Accountability_in_the_Public_Sector_with_cover.pdf. Published 2005. Accessed September 11, 2018.

Social Accountability in Health Care: Social accountability in health care prioritizes the health concerns of the people and communities served, with an implicit goal of health equity. It is "the obligation [of physicians and medical institutions] to direct their education, research and service toward addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve."

- Boelen C, Heck JE. Defining and measuring social accountability in medical schools. World Health Organization. Division of Development and Human Resources for Health.

http://apps.who.int/iris/bitstream/handle/10665/59441/WHO_HRH_95.7.pdf?sequence=1&isAllowed=y. Published 1995. Accessed September 11, 2018.

Social Determinants of Equity (SDoE): Human-made social determinants—such as racism, sexism, ageism, ableism, homo- and trans- phobia—that inequitably distribute power, and create inequities in the social and biological determinants of health.

Addressing SDoE is necessary to achieve social justice and eliminate health disparities, whereas addressing SDoH targets health outcomes.

Addressing SDoE requires:

- monitoring for inequities in exposures and opportunities, as well as for disparities in outcomes;
- examination of structures, policies, practices, norms, and values; and
- intervention on societal structures and attention to systems of power.
 - Jones CP, Jones C Y., Perry, G. S., Barclay, G., Jones, C. A. Addressing the social determinants of children's health: A cliff analogy. *Journal of Health Care for the Poor and Underserved*. 2009; 20(4) 1-12. Jones C. Presentation at CDC. <https://minorityhealth.hhs.gov/Assets/pdf/Checked/1/CamaraJones.pdf>. Accessed May 16, 2018.

Social Determinants of Health (SDoH): “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”

- Social Determinants of Health. HealthyPeople.gov website. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. Accessed June 9, 2018.

Social Risk Factors: Factors such as low socioeconomic position (as indicated, for example, by income or educational level), minority race or ethnic background, lower degree of acculturation, minority sexual orientation or gender identity, limited social relationships, and living alone or in a deprived neighborhood that negatively influence health outcomes.

- Buntin MB, Ayanian JZ. Social risk factors and equity in Medicare payment. *New Engl J Med*. 2017;376(6):507-10.

Socioeconomic Status (SES): The social standing or class of an individual or group. It is often measured as a combination of education, income and occupation.

- American Psychological Association website. <http://www.apa.org/topics/socioeconomic-status/>. Accessed September 11, 2018.

Stereotype Threat: The experience of anxiety in a situation in which a person has the potential to confirm a negative stereotype about his or her social group.

- Inzlicht M. *Stereotype threat: theory, process, and application*. New York, NY.: Oxford University Press;2012.

Structural Competency: Improving understanding of how social conditions, historical context, and practical logistics undermine the capacities of patients to access health care, adhere to treatment, and modify lifestyles successfully. The ability for health professionals to recognize and respond with self-reflexive humility and community engagement to the ways negative health outcomes and lifestyle practices are shaped by larger socio-economic, cultural, political, and economic forces.

- Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. *Acad Med*. 2017;92(3):299-307. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5233668/>. Accessed May 17, 2018.
- Holmes S. *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States*. Berkeley, Calif: University of California Press; 2013

Structural Inequality: Bias that is built into the structure of organizations, institutions, governments, or social network.

- Structural inequality. Wikipedia. https://en.wikipedia.org/wiki/Structural_inequality. Published [November 3, 2011]. Updated [July 27, 2018]. Accessed [September 12, 2018].

There is a “growing awareness that social justice must be understood as a structural phenomenon encompassing a complex interplay of economic, racial, gender, and political dimensions.... contesting structural inequality is a central theme in the many social movements today.”

- Rahman KS. Structural inequality and the law, part II. Law and Political Economy. Available at <https://lpeblog.org/2018/03/05/structural-inequality-and-the-law-part-ii/>. Adapted from, Rahman KS. Constructing and contesting structural injustice. *Critical Analysis of Law*. 2018; 5(1). <https://cal.library.utoronto.ca/index.php/cal/article/view/29507/21992>. Accessed September 12, 2018.

Structural Violence: One way of describing social arrangements that put individuals and populations in harm’s way... The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people.

- Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. *Acad Med*. 2017;92(3):299-307.
- Quesada J, Hart L, Bourgois P. Structural vulnerability and the health of Latino migrant laborers. *Med Anthropol*. 2011;30(4):339–362.

Structural Vulnerability: An individual's or a population groups' condition of being at risk for negative health outcomes through their interface with socioeconomic, political and cultural/normative hierarchies. Patients are structurally vulnerable when their location in their society's multiple overlapping and mutually reinforcing power hierarchies (e.g., socioeconomic, racial, cultural) and institutional and policy-level statuses (e.g., immigration status, labor force participation) constrain their ability to access healthcare and pursue healthy lifestyles.

- Bourgois P, Holmes SM, Sue K, Quesada J. Structural vulnerability: Operationalizing the concept to address health disparities in clinical care. *Acad Med.* 2017;92(3):299-307.

Transactional Metric: An objective, often numeric, outcome that can be quantitatively measured (e.g., the number of surveys distributed and the number of surveys completed). Transactional data *does not* provide much insight into the quality of the data fields they are tracking.

Transformational Metric: A metric that demonstrates behavioral change and is fundamentally relationally driven. It highlights not only outputs but outcomes.

Trauma-informed Approach: "A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
 2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
 3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
 4. Seeks to actively resist *re-traumatization*."
- Trauma-Informed Approach and Trauma-Specific Interventions. Substance Abuse and Mental Health Services Administration website. <https://www.samhsa.gov/nctic/trauma-interventions>. Accessed June 9, 2018.

Unconscious (Implicit) Bias: The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purposes of social and/or political correctness. Rather, implicit biases are not accessible through introspection.

- Implicit biases are pervasive. Everyone possesses them, even people with avowed commitments to impartiality such as judges.

- Implicit and explicit (conscious) biases are related but distinct mental constructs. They are not mutually exclusive and may even reinforce each other.
- The implicit associations we hold do not necessarily align with our declared beliefs or even reflect stances we would explicitly endorse.
- We generally tend to hold implicit biases that favor our own ingroup, though research has shown that we can still hold implicit biases against our ingroup.
- Implicit biases are malleable. Our brains are incredibly complex, and the implicit associations that we have formed can be gradually unlearned through a variety of debiasing techniques.
 - Understanding Implicit Bias. The Ohio State University Kirwan Institute for the Study of Race and Ethnicity website. <http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/>. Accessed June 9, 2018.

Undocumented Immigrant: Any foreign national who has (1) legally entered the nation state or territory but remained in the country after their visa/permit expired; (2) received a negative decision on their refugee/asylee application but remained in the country; (3) experienced changes in their socioeconomic position and could not renew residence permit but remained in the country; (4) used fraudulent documentation to enter the country or territory; or (5) unlawfully entered the country or territory, including those who were smuggled.

- Martinez O, Wu E, Sandfort T, Dodge B, Carballo-Diequez A, Pinto R, et. al.. Evaluating the impact of immigration policies on health status among undocumented immigrants: A systematic review. *J Immigr Minor Health*. 2015;17(3):947-70.

Upstream Determinants of Public Health (Upstream): Overarching factors that are largely outside of the control of the individual and which have significant trickle down effects on other, more proximal, determinants of public health. Much the same way that pollution upstream of a river will have lasting and far reaching effects on those populations downstream, despite these populations having little to no control over this pollution.

Urban: Urban areas include *Urbanized Areas*, which contain >50,000 people, and *Urban Clusters*, which contain between 2,500 and 50,000 people.

- Defining Rural Population. Health Resources & Services Administration website. <https://www.hrsa.gov/rural-health/about-us/definition/index.html>. Accessed June 9, 2018.

Value-Based Programs/Payments/Reimbursement Models: Value-based programs reward health care providers with incentive payments for the quality of care. They are part of a larger quality strategy to reform how healthcare is delivered and paid for. They aim to move toward paying providers based on the quality, rather than the quantity of care they give patients.

- What are the Value-Based Programs? CMS.gov website. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html>. Accessed June 9, 2018.

Vulnerability: “Vulnerability involves several interrelated dimensions: individual capacities and actions; the availability or lack of intimate and instrumental support; and neighborhood and community resources that may facilitate or hinder personal coping and interpersonal relationships.”

- Mechanic D, Tanner J. Vulnerable people, groups, and populations: Societal view. *Health Aff* (Millwood). 2007;26;1220-1230.

Vulnerable Populations: Groups of persons whose range of options is severely limited, who are frequently subjected to coercion in their decision making, or who may be compromised in their ability to give informed consent.

- Vulnerable Populations MeSH Descriptor Data 2018. National Library of Medicine website. <https://meshb.nlm.nih.gov/record/ui?ui=D035862>. Accessed September 17, 2018.

Weathering (biological weathering): “namely, that the health of African-American women [and men] may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage.”

- Geronimus AT. The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethn Dis*. 1992;2(3):207-221.

WONCA (World Organization of Family Doctors): WONCA was founded as a collaboration of multiple international primary care organizations in 1972. The mission of WONCA is to improve quality of life of people around the world. WONCA represents and acts as an advocate for its constituent members at an international level where it interacts with world bodies such as the World Health Organization (WHO), with whom it has official relations as a non-governmental organization and is engaged in a number of collaborative projects.

HEALTH EQUITY RESOURCES

DATABASES

Centers for Disease Control and Prevention

The Community Guide

<https://www.thecommunityguide.org/>

- The Guide to Community Preventive Services (The Community Guide) is a collection of evidence-based findings of the Community Preventive Services Task Force (CPSTF) - organized by over 20 public health topics, including health equity. These findings support interventions to improve health and prevent disease at the macro and meso levels. Resources answer what has worked for others, cost considerations, and highlight evidence gaps. They also provide actionable tools to guide community-engaged work.

Community Health Rankings

<http://www.countyhealthrankings.org>

- The annual rankings from the Robert Wood Johnson Foundation provide a snapshot at the county-level of how health is influenced by where we live, learn, work and play. Ranking communities on health outcomes and health factors, including social determinants of health, they provide a starting point for change in communities.
- The website also provides extensive resources, including State Health Gap Reports that highlight health disparities and an Action Center with tools for each stage of the process to make communities healthier.
 - **State Health Gap Reports:** <http://www.countyhealthrankings.org/health-gaps>
 - **Action Center:** <http://www.countyhealthrankings.org/roadmaps/action-center>

Practical Playbook

<https://www.practicalplaybook.org>

- The Practical Playbook strives to advance collaboration among public health, primary care, and others to improve population health. Within this website are practical implementation tools, guidance, and resources including success stories to inspire and encourage expansion of such work.

Unnatural Causes

<http://www.unnaturalcauses.org/>

- This seven-part acclaimed documentary series broadcast by PBS is now used by thousands of organizations to tackle the root causes of our alarming socio-economic and racial inequities in health.

Online Collection of Health Equity Resources

<http://www.unnaturalcauses.org/resources.php>

- This database contains hundreds of articles, websites, video clips, charts, datasets, interviews, transcripts, and educational and outreach materials. It is searchable by topic, the documentary episode topics, type, and keyword.

REPORTS and PROCEEDINGS

Bachrach D., Pfister H., Wallis K., and Lipson M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund website. May 29, 2014.

<http://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs> Accessed September 17, 2018.

- This report outlines how growing numbers of clinicians are concluding that investing in interventions addressing their patients' social needs makes good business sense. As more low-income people gain health care coverage, evidence on which interventions are most cost-effective in addressing their social needs and improving their health will grow, and value-based reimbursement will become standard across payers.

National Academies of Sciences, Engineering, and Medicine. Communities in action: Pathways to health equity. 2017. Washington, DC: The National Academies Press. doi: 10.17226/24624.

<https://doi.org/10.17226/24624>.

- This report “seeks to delineate the causes of and the solutions to health inequities in the United States. This report focuses on what communities can do to promote health equity, what actions are needed by the many and varied stakeholders that are part of communities or support them, as well as the root causes and structural barriers that need to be overcome.”

National Academies of Sciences, Engineering, and Medicine. Exploring equity in multisector community health partnerships: Proceedings of a workshop. 2017. Washington, DC: The National Academies Press. <http://nationalacademies.org/hmd/reports/2017/exploring-equity-in-multisector-community-health-partnerships-proceedings.aspx>

- This report—summarizing a workshop hosted by the Roundtable on Population Health Improvement of the National Academies of Sciences, Engineering and Medicine—explores how a variety of successful community-based organizations created and maintained innovative and sustainable approaches to multisector community health partnerships.

Institute of Medicine. Spread, scale, and sustainability in population health: Workshop summary. 2015. Washington, DC: The National Academies Press.

<https://www.nap.edu/catalog/21708/spread-scale-and-sustainability-in-population-health-workshop-summary>

- This report summarizes a workshop convened by the Institute of Medicine's Roundtable on Population Health Improvement to discuss the spread, scale, and sustainability of practices, models, and interventions for improving health in a variety of inter-organizational and geographical contexts. It explores how users measure whether their strategies of spread and scale have been effective and discusses how to increase the focus on spread and scale in population health.

Using Data to Impact Community Health and Drive Action. Practical Playbook website.

<https://www.practicalplaybook.org/resources/using-data-impact-community-health-and-drive-action>. Accessed September 17, 2018.

- This report from the 2017 Practical Playbook National Meeting “Improving Population Health: Collaborative Strategies That Work” identifies problems most likely to occur in partnerships between public health and primary care, and offers practical, actionable strategies to share data across sectors.

Effective Strategies to Build Momentum and Realign Population Health Programs in a Changing Healthcare Landscape. Practical Playbook website.

<https://www.practicalplaybook.org/resources/effective-strategies-build-momentum-and-realign-population-health-programs-changing-healthcare>

Accessed September 17, 2018.

- This report from the 2017 Practical Playbook National Meeting “Improving Population Health: Collaborative Strategies That Work” shares specific, workable steps for addressing the social determinants of health and proven best practices for working across sectors effectively

Demonstrating Value in Population Health Projects. Practical Playbook website.

<https://www.practicalplaybook.org/resources/demonstrating-value-population-health-projects>

Accessed September 17, 2018.

- This report from the 2017 Practical Playbook National Meeting “Improving Population Health: Collaborative Strategies That Work” identifies strategies to help cross-sector collaborations define value to all partners and ensure their ongoing support.

INTERPROFESSIONAL TEACHING/FACILITATION RESOURCES

TRAININGS

IPE Facilitation Training Toolkit. Center for Health Sciences Interprofessional Education University of Washington website. <https://collaborate.uw.edu/ipe-teaching-resources/ip-curriculum-educators/ipe-facilitation-training-toolkit/>

Accessed September 17, 2018.

- This toolkit is designed for educators interested in learning to facilitate student Interprofessional Education (IPE) and/or train other educators to facilitate IPE. It contains free-source activities and methods to actively engage educators in learning and applying various instructional methods to teach IPE competencies. All materials for each activity are available for download and use. The purpose is to help facilitators understand common facilitation challenges in interprofessional learning groups and to help facilitators identify situations in which particular/effective facilitation strategies could be employed.

ARTICLES

Crow J., Smith L. Using co-teaching as a means of facilitating interprofessional collaboration in health and social care. *J Interprof Care*. 2003; 17(1): 45-55.

<http://informahealthcare.com/doi/pdf/10.1080/1356182021000044139>.

- For a group of interprofessional students, this article highlights the process of using co-teaching (by facilitators with different professional/academic backgrounds) to role model shared learning and collaborative working within the classroom and highlight the importance of carefully planning co-teaching interaction, including the use of humor, tension, different knowledge bases and styles of debate. The deliberate use of the interactions made possible by co-teaching enabled the authors to create an active learning environment that facilitated the teaching of collaboration. They discuss the considerable potential of using co-teaching to role model collaborative working for multidisciplinary student groups.

Di Prospero L., Bhimji-Hewitt S. Learning is in the facilitation: Faculty perspectives with facilitated teaching and learning-recommendations from informal discussions. *J Allied Health*. 2011; 40(4): e61–65.

- This article recommends using facilitator guides with specific debrief instructions for the given objectives in order to encourage effective learning dialogue among all participants, formalized facilitator training, and debrief strategies in order to attain the skills to better guide student learning.

Equity and Empowerment Lens Assessment Worksheet

What is the Purpose? /Define Outcomes

1. Circle which area this intervention/practice/policy will primarily impact:
 - a. Clinical health metric (e.g. hemoglobin A1c)
 - b. Access to services
 - c. Social determinant of health (e.g. education, housing)
 - d. Other

2. What are you or your team trying to improve?

3. Who does this intend to serve?

4. What data or evidence guides this intervention/practice/policy/etc. (Consider all demographic data; maps; qualitative experience, etc.)?

5. What is the data telling you about inequities experienced in the community?

6. Does the data take into account community priorities and culturally-specific feedback?

Connection to People

7. Who, in the community and in your organization, will be most affected by and concerned with this intervention/practice/policy? Consider positive and negative impacts to the physical, mental, spiritual and contextual health of groups including for potential trauma/re-trauma; and to the distribution of resources. Have you sought their input?

Demographics (group affected – be specific and consider staff)	Differential impacts Positive – benefit	Differential impacts Negative – burden	Structural causes for benefits and burdens*

*Think deep (e.g. challenge yourself to consider not merely “lack of funding” but why is there lack of funding?)

Connection to Place

8. Does this intervention/practice/policy account for a person or group's emotional or physical safety?

9. Does this intervention/practice/policy affect the environment or are there issues of environmental justice to consider?

10. How are resources and investments distributed geographically?

Connection to Process and Power

11. What barriers do you and your team encounter in making changes related to equity and racial justice?

12. How does your organization engage the community in planning, decision-making and evaluation?

a. What policies, processes and social relationships intentionally include communities affected by inequities?

b. What policies, processes and social relationships contribute to the exclusion of communities most affected by inequities?

c. What actions or strategies could build inclusion?

13. How does the intervention/practice/policy build community capacity and power in communities most affected by inequities?

References: The Equity and Empowerment Lens Worksheet is adapted from Equity and Empowerment Lens 2012. Multnomah County Office of Diversity and Equity.
<https://multco.us/file/31833/download> Accessed November 13, 2018.

Five possible key questions:

- **PURPOSE:** What is the problem you are trying to solve? Describe your proposed intervention.
- **PEOPLE:** Which patients are positively and negatively affected by this intervention?
- **PLACE:** How does this intervention account for patients' emotional and physical safety and their need to be productive and feel valued?
- **PROCESS:** How are we meaningfully including and excluding patients in the process?
- **POWER:** How could we better integrate voices and priorities of all stakeholders?